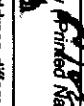
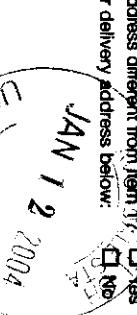


SENDER: COMPLETE THIS SECTION		COMPLETE THIS SECTION ON DELIVERY	
<input checked="" type="checkbox"/> I complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.		<input checked="" type="checkbox"/> I.V.-U.S. <input checked="" type="checkbox"/> Print your name and address on the reverse side so that we can return the card to you. <input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.	
Case 1: 00-00000000000000000000000000000000 Cincinnati Children Hospital Medical Center 3333 Burnet Ave. Cinci, OH 45229-3026		A. Signature  RELAY Exam <input checked="" type="checkbox"/> Agent ES <input checked="" type="checkbox"/> Addressee B. Received by  Express Delivery C. Date  D. Is delivery address different from item 1? <input checked="" type="checkbox"/> Yes If YES, enter delivery address below: <input checked="" type="checkbox"/> No	
3. Service Type <input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Registered <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.		4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes	